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From: Elias_Nathan [Elias_Nathan@Allergan.com]
Sent: Monday, February 28, 2011 9:56 AM
To: MedicaidReforms [KHPA]
Subject: Proposal for Kansas Medicaid for Long-term Savings and Quality of Services Improvement
Attachments: KS_Medicaid.pdf



Allergan is a global, technology-driven multi-specialty health care company pursuing therapeutic advances to help patients live life to their fullest potential. Allergan has joined the effort to fight the growing obesity epidemic with a portfolio of innovative medical devices to help achieve and support sustained weight loss, reduce health risks associated with obesity and help patients realize their goals for healthy living and wellness. The LAP-BAND® Adjustable Gastric Banding System is the first adjustable medical device for individualized weight loss and the first minimally invasive surgical approach approved in the United States by the U.S. Food and Drug Administration. Allergan is committed to enabling patients to reach a natural healthy weight and to live an active lifestyle. Over the last 50 years, obesity has been increasing at an alarming rate and is now recognized by leading government health authorities, such as the Centers for Disease Control (CDC) and National Institutes of Health (NIH), as a disease. In the United States alone, obesity affects more than 60 million individuals and is considered the second leading cause of preventable death.

45 out of the 50 states' Medicaid programs currently cover bariatric surgery as an approved treatment for weight loss in the chronically obese population. Kansas currently does not cover bariatric surgery intervention for weight loss in chronically obese people in either the Medicaid program or in the state employee health plan. As we all know, obesity is not only a growing epidemic in our country but becoming one of the most significant cost-drivers in our health care system as well. In the case of chronically obese people, this is especially true due to the overwhelming number of co-morbid conditions that come with the obesity – diabetes, congestive heart failure, chronic lipidemia, etc. The attached fact sheet addresses several of these issues and also addresses recent studies which have shown the ROI on bariatric surgery to be as low as 2 years, the savings coming in reduction of treatment costs for the co-morbid conditions which significantly improve with the loss of weight, and then long-term cost savings for the treatment of this population following.

Simply put, the State of Kansas approving coverage for this type of weight loss intervention would be an effective long-term cost controlling measure in the chronically obese population in the Medicaid program – a population that is a significant cost driver in the health care matrix.

More specifically, we would like to also draw your attention to a proposal also being submitted through KHPA's requests for ideas from Policy Studies Inc. (PSI) called the Weight Reduction Assistance Program or WRAP. This proposal is a joint effort between Allergan and PSI, and we believe would be a exciting program to pursue with the State of Kansas.

Both PSI and Allergan are looking forward to working with you to try to bring this important cost-saving and chronic disease management tool to Kansas.

Thank you and please do not hesitate to contact me if there are further questions about this proposal.

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Economic Impact of Obesity and Costs Savings Investment from Bariatric Surgery

Obesity, defined as a body mass index (BMI) of 30 or greater, is broken into 3 classifications:

- Class I (BMI of 30 to 34.9), Class II (BMI of 35 and 39.9) or Class III (BMI of 40 or greater).¹
- Class III obesity is also referred to as clinically severe or morbid obesity.¹
- Based on data from the National Health and Nutrition Examination Survey (NHANES), more than 1/3 of U.S. adults ≥ 20 years of age, or over 72 million people,² were obese with a body mass index (BMI) ≥ 30 kg/m² in 2007-2008.³
 - Prevalence of obesity has more than doubled in adults aged 20-74 since 1980²⁵
- The prevalence of **extreme** obesity (BMI ≥ 40) in 2007-2008 was 5.7%.
 - 4.2% in men ≥ 20 years old and 7.2% in women ≥ 20 years old³

CDC reports that more than 133 million Americans — approximately 45% of the total population — have at least one chronic disease.

- Chronic diseases kill more than 1.7 million Americans yearly, and account for a third of years of potential life lost before age 65.⁵
- Previous research has linked rising obesity rates to rising rates of costly health ailments, particularly chronic conditions such as diabetes, heart disease, high blood pressure (hypertension) and elevated cholesterol (hyperlipidemia).⁵
 - Managing co-morbidities associated with obesity contributes significantly to costs.
- For those individuals with BMI > 35 kg/m², excess weight is associated with substantial decreases in life expectancy⁶
 - For higher BMI categories, the reduction in life expectancy becomes “much more pronounced”.⁶

Costs of Obesity

Obesity was estimated in 2008 to cost the U.S. health care system up to \$147 billion a year.

- Adult per capita medical spending attributable to obesity (compared to normal weight) was an extra \$1,429 per year for each obese person in 2006 (in 2008 dollars).⁷
 - The increased prevalence of obesity is responsible for almost \$40 billion of increased medical spending through 2006, including \$7 billion in Medicare prescription drug costs.⁷
- Unadjusted healthcare costs were 72% and 20% higher for the BMI ≥ 35 and BMI ≥ 30 but < 35 groups, respectively, as compared to the BMI ≥ 18.5 but < 25 group among individuals with self-insured employers.⁸
 - Patients with BMI ≥ 35 kg/m² miss more days of work (mean=37.8 work days lost to absences/paid time off) than patients of normal weight (mean=15.9) annually, corresponding to \$8,433 and \$3,488 in indirect costs to employers, respectively.⁸
- ◆ Obese individuals take more sick leave and spend less time at work (both in terms of absenteeism and reduced productivity while at work) than healthy weight employees.^{9,10}
- ◆ The rate of workplace injuries and disability is significantly higher for obese employees.⁹
- ◆ U.S. cost estimates for obesity-attributable absenteeism ranged from \$3.38 billion to \$6.38 billion.¹¹
- ◆ The overall, tangible, annual cost of being obese (as estimated using the cost of direct medical expenses, short-term disability, disability pension insurance, reduced productivity, gasoline for cars, and life insurance, as well as reduction in wages) is \$4,879 for an obese woman, and \$2,646 for an obese man, as compared to \$524 and \$432 for overweight women and overweight men, respectively.²⁴

Reduced Costs and Improved Health after Bariatric Surgery

- Both laparoscopic gastric bypass and laparoscopic adjustable gastric banding are safe and effective bariatric procedures for the treatment of morbid obesity.¹²
- In one study, the 30-day rate of death among patients who underwent Roux-en-Y gastric bypass or laparoscopic adjustable gastric banding was 0.3%, and only 4.3% of patients had at least one major adverse outcome, which lead the authors to conclude that the “overall risk of death and other adverse outcomes after bariatric surgery was low”.¹³
- ♦ Several studies show that serious obesity comorbidities such as diabetes, hyperlipidemia, hypertension and sleep apnea can be completely resolved or reduced following weight loss surgery. According to the Buchwald meta-analysis:¹⁴
 - Type 2 diabetes completely resolved in 76.8% of patients and resolved or improved in 86%
 - Hyperlipidemia improved in 70% of patients
 - Hypertension resolved in 61.7%, resolved or improved in 78.5%
 - Sleep Apnea resolved in 85.7% of patients, and resolved or improved in 83.6%
- ♦ In patients treated with bariatric surgery, the risk of 5-year mortality is reduced by approximately 89%.¹⁵
- ♦ Drug expenditures for comorbidity-related medical expenses were reduced by \$182 a month following Roux-en-Y gastric bypass, resulting in annual savings of \$2,184 per patient.¹⁶
- ♦ Compared with gastric bypass, gastric banding was associated with a shorter operative time, shorter length of hospital stay, lower perioperative, and late morbidities, and lower rates of 30-day readmission and reoperation. However, medium and long-term weight loss was consistently and dramatically better after gastric bypass as compared to gastric banding, as weight loss after gastric banding was variable, with a small proportion of patients failing to lose weight.¹²

Costs Savings from Bariatric Surgery Investment

- ♦ Laparoscopic adjustable gastric banding and gastric bypass surgery are cost-effective (at <\$25,000/quality adjusted life-year) treatment options compared to non-surgical interventions.¹⁷
- ♦ A 2003 Veterans Affairs study showed that the cost of undertaking Roux-en-Y gastric bypass at the VA is offset by reduction of health-care costs within the first year after surgery.¹⁸
- ♦ The Cremieux study in 2008 showed that insurers fully recovered costs of laparoscopic bypass/open bypass bariatric surgery within 2 to 4 years, depending on procedure type.¹⁹
- ♦ In 2010, Finkelstein showed that the initial payments for laparoscopic adjustable gastric were fully recovered within 4 years (16 quarters) for the surgery-eligible morbidly obese population, and in just more than 2 years (9 quarters) for morbidly obese surgery-eligible individuals with diabetes. In contrast, the payments for the control group continued to increase.²⁶
- ♦ The Finkelstein study in 2005 showed that obese workers eligible for bariatric surgery had higher absenteeism and \$2230 higher annual medical costs than persons of normal weight. The authors estimated a five to ten year return on investment when looking at direct medical and absenteeism costs.²⁰

Policy/Coverage

Bariatric surgery is an approved treatment for weight loss in the severely obese.

- ♦ Centers for Medicare & Medicaid Services implemented a national coverage decision in 2006.¹³
- ♦ 45 states cover bariatric surgery for Medicaid patients
- ♦ Numerous states are providing bariatric surgery for their state employees.

The following organizations recommend bariatric surgery for the treatment of severe obesity:

- ♦ NIH issued a consensus statement explaining that “gastric restrictive or bypass procedures could be considered for well-informed and motivated patients with acceptable operative risks.”

- ♦ Blue Cross Blue Shield Association (2007) published positive TEC evaluation of laparoscopic adjustable gastric banding¹⁴
- ♦ Agency for Healthcare Research and Quality (AHRQ) 2004 technology assessment concluded that "surgical treatment is more effective than nonsurgical treatment for weight loss and the control of some comorbidities in patients with a body mass index of 40 kg/m² or greater," but that more data are needed to confirm or refute the relative efficacy of surgery for less severely obese persons.¹⁵

Common Eligibility Requirements for Bariatric Surgery

While specific policies vary by health plan, most in the U.S. generally include the following eligibility criteria:

- ♦ A Body Mass Index (BMI) above 40 kg/m²; OR
- ♦ BMI of 35 kg/m² or greater with obesity-related co-morbid medical conditions including: (for example, diabetes, hypertension, cardiopulmonary condition, sleep apnea, osteoarthritis); AND
- ♦ Failed non-surgical attempts at weight loss (e.g., supervised weight loss program, medications, exercise); AND.
- ♦ Completion of a psychological examination of the member's readiness for surgery and the necessary postoperative lifestyle changes

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